Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACCESS MEDIQUIP
PO BOX 421529
HOUSTON TX 77242

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-07-1389-01

MFDR Date Received
NOVEMBER 3, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "All equipment needed for restore neurostimulator."

Amount in Dispute: $8,976.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. This dispute involves Texas Mutual's reduction/denial of payment of code E1399, E0754, and A4649 billed for date of service 12/8/2005. The requestor billed $10,930.00; Texas Mutual paid $654.50. The requestor believes it is entitled to an additional $8,976.95. 1. When there is no established MAR for a service then the payment is subject to fair and reasonable reimbursement standards identified in Section 413.011(d) of the Texas Labor Code. In this case, 'The DWC Medical Fee Guideline, is required to be fair and reasonable per Section 413.011(d) which states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effect medical cost control…." DWC Rule 134.202 (c)(2) for Healthcare Common Procedure Coding System (HCPCS Level II codes A, E, J, K, and L:.. (A) 124% of the fee listed for the code in the Medicare Durable Medical Equipment Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;…." 2. In December of 2005, the Centers for Medicare and Medicaid Services (CMS) published the 2006 update of the DMEPOS fee schedule, which includes new Level II Healthcare Common Procedure Coding System (HCPCS) codes developed to differentiate rechargeable and non-rechargeable neurostimulators. In 2006 with regard to HCPCS codes for neurostimulator devices, the existing "E" codes for spinal cord stimulation were discontinued from the Level II HCPCS coding system and are no longer effective under Medicare for dates of service after December 31, 5005 [sic]. Currently, there is a new series of "L" codes that describe spinal cord stimulation technologies (L8680-L8689). 3. This requestor billed for a recharging system with antenna and extension under miscellaneous code E1399, in the absence of a specific HCPCS code. Texas Mutual utilized the current HCPCS Code L8689, for the 1x8 extension billed under HCPCS code E1399, is global to the implantable pulse generator billed on the same date of service according to Medicare's HCPCS coding; therefore, no separate payment is due for the 1x8 extension billed under miscellaneous code E1399. 4. Texas Mutual will allow additional payment for the patient program kit based on the current HCPCS code, L8681. Payment is based on Palmetto GBA, DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, Supplies) fee schedule. Payment to the requestor will follow under separate cover. 5. Code A4649, is the accessory kit with needle. It is this carrier's position that no reimbursement is due for these supplies associated with the implantable pulse generator as reimbursement for these supplies is included in the implantable pulse generator. The Medicare Physician Fee Schedule status indicator for code A4649 is 'P' which is defined as: [cut and pasted information provided by respondent is

illegible]. Given the above, Texas Mutual respectfully asks that the requestor withdraw its request for dispute resolution."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2005	E1399 – Recharging system and antenna	$5,080.00	$0.00
December 8, 2005	E1399 – 1x8 Extension	$2,780.00	$0.00
December 8, 2005	E0754 – Patient programmer	$2,380.00	$426.95
December 8, 2006	A4649 – Accessory Kit	$690.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of treatment/services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 20, 2006 and August 28, 2006:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaulate this upon receipt of clarifying information.
   - 50 – These are no-covered services because this is not deemed a 'medical necessity' by the payer.
   - 244 – Unnecessary medical
   - 97 – Payment is included in the allowance for another service/procedure.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - 18 – Duplicate claim/service.
   - 878 – Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 420 – Supplemental payment.
   - 426 – Reimbursed to fair and reasonable.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

3. The requestor billed HCPCS code E1399 twice, once for the recharging system and external antenna and once for the 1x8 extension. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that: Although the requestor submitted a copy of the Sales Edit List/Sales Order Processing, the requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute; therefore, the requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
4. The requestor also billed HCPCS Code E0754 defined as Patient programmer (external) for use with implantable programmable neurostimulator pulse generator. According to the DMEPOS fee schedule for 2005 this item carries a value in Texas of $865.16. The respondent reimbursed the requestor and amount of $654.40 for this specific HCPCS code. In accordance with 28 Texas Administrative Code §134.203(d)(1-3) states that the MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2)if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3)if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section. Section (f) states that for products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

   The respondent initially denied this services using denial code 50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer" and 244 – "Unnecessary medical." The respondent did not uphold this denial upon reconsideration and made a partial payment. The respondent has stated in their position summary that, "Texas Mutual will allow additional payment for the patient program kit based on the current HCPCS code, L8681. Payment is based on Palmetto GBA, DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, Supplies) fee schedule. Payment to the requestor will follow under separate cover." The respondent's agent, Linda Estrada, was contacted on February 19, 2013 via e-mail and asked to submit a payment summary and explanation of benefits to support that additional payment was made to the requestor. A response to this request was not submitted; therefore additional reimbursement in the amount of $426.95 ($865.16 x 125% = $1,081.45 - $654.50) is due.
5. The requestor also billed HCPCS Code A4649 – Accessory Kit. According to the 2005 HCPCS Level II book this code is defined as a surgical supply; miscellaneous and has an APC status indictor of "A". "A" indicates services that are paid under some other method such as the DMEPOS fee schedule or physician fee schedule. According to the respondents position summary "no reimbursement is due for these supplies associated with the implantable pulse generator as reimbursement for these supplies is included in the implantable pulse generator. Review of this code in the DMEPOS fee schedule reveals this code is not priced by Medicare and is considered a bundled/excluded code. As a result, the amount ordered is $0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $426.95.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $426.95 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.